KANSAS MEDICAL JOURNAL.

VOL. VII. TOPEKA, KANSAS, SATURDAY, DECEMBER 21, 1895. No. 51.

ORIGINAL ARTICLE.

Appendicitis.

BY GEO. M. GRAY, M.D., KANRAS CITY, KAS.

Read before the Kansas Medical Society, May, 1895.

Inflammation of the appendix vermiformis, or appendicitis, is a subject that has received a great amount of attention during the past five years, both from surgeons and physicians. The pathology of the disease has been closely studied, and the information gained from early operation has been of great value in clearing up the pathology, and giving a clear understanding of the pathological condition in the early stage of the disease. From knowledge gained in this manner, and from post mortem examinations, we have learned that affections of the appendix vermiformis are the cause of almost all inflammations of the right iliac fossa, and perityphlitis and ileo-cecal abscess are diseases now known to be secondary to and caused by inflammation of the appendix; and we have also learned that there is no such disease as idiopathic peritonitis, but that all cases of peritonitis starting or having their origin in the region of the caput-coli are, almost without exception, dependent upon a diseased condition of the appendix; that inflammation of the vermiform appendix is of common occurrence is now generally admitted, and observations made on the post mortem table have shown it to have been the seat of inflammation in about one-third of all subjects examined; this has been one of the strong points advanced by physicians who have contended for the medical treatment for certain forms of inflammation of the appendix, but valuable light has been thrown on this point by Byron Robinson of Chicago. In his recent article in the *Medical Review* entitled "Observations on the Abdominal Viscera in Seventeen Autopsies." Of these cases he found evidences of old peritonitis in the right iliac fossa in twelve out of seventeen cases examined; but on examination of the left iliac fossa he found distinct old peritonitic adhesions twelve times, and says in his report that twelve adult cadavers out of seventeen examined had distinctly marked old peritonitic adhesions over the psoas muscle, where the sigmoid crossed it, and accounts for it by the irritation of the ileo-psoas muscle. If this be true, is it not possible that the inflammations so often observed in the region of the caput-coli in the cadaver is not always the result of old inflammations of the appendix, but caused from the same irritation as that occurring at the same point on the left side? If this observation be true, it is of importance, and will reduce considerably the number known to recover without operation from this affection, for I feel sure that no surgeon or physician who has had an opportunity of observing the pathological condition of the appendix during an attack of appendicitis can be but surprised that so large a number should recover, as seem to be indicated by observations made on the cadavers. Before entering upon the symptomatology and treatment of appendicitis allow me to briefly describe the appendix and its location. It is generally regarded as a functionless organ of the atrophic type, variable in size, length and position; found only in man and the higher apes; entirely surrounded by peritoneum unless it be a small portion at base; located within the abdominal cavity, and generally occupying the right iliac fossa, but in some

cases where the cæcum is arrested in its descent, the appendix may be found high up in the regionof the liver or gall-bladder; or in other cases it may descend lower than normal and occupy the pelvis, or, even be found to the left of the median line; indeed, in some cases, it may be contained in either a right or left hernia, especially in children. Such a case I saw a few months ago at St. Margaret's Hospital in Doctor Perkins' service; a baby about eighteen months old, with left oblique inguinal hernia, in which there was a sinus leading into the sac. On opening the sac he found the cæcum and appendix incarcerated; the appendix had been the seat of perforative inflammation, with abscess formation, the abscess burrowing through the scrotal tissues, leaving the sinus leading up to it. When the appendix is located in the normal position in the right iliac fossa, the position it may occupy is variable; sometimes occupying a position behind the cæcum, at other times hanging over the brim of the pelvis or out into the median line, the most frequent position being pointing towards the spleen. The length of the appendix varies, being from one to seven inches in length and containing three coats, serous, muscular and mucous; the muscular coat consisting mostly of longitudinal fibres, and contains within a number of closed follicles. Dr. Robinson observed the direction in which the appendix pointed in nine cases and found that in four it pointed toward the spleen, in two toward the liver, and in one toward the middle of the lateral pelvic wall, and one toward the middle of the iliac crest and one toward the iliac spine. He also noted the position of the appendix in twelve cases; it lay behind the cæcum four times, across the psoas muscle five times, and to the right of the psoas muscle three times. He also noted that in the male adult nearly 25 per cent. of appendices hang in the pelvis, and over 25 per cent. in women. A condition that is important to remember, for in this position it becomes much more dangerous than when in its normal position, where protecting adhesions are more certain to form.

As to different forms of inflammation of the appendix, numerous classifications have been suggested by different observers, such as catarrhal, perforative, ulcerative, etc., I believe that the classification given by Dr. John B. Murphy, of Chicago, indicates more clearly the pathological condition existing in the several forms. His classification is, first, simple pus infection, which produces the catarrhal variety; second, extensive pus infection by the bacillus commune or pyogenic microbe producing gangrene in a greater or less portion of the appendix; third, pressure atrophy, with infection of the appendix, either by fecal concretions or foreign bodies; fourth, retention accumulations from cicatricial contractions, stenosis or obliteration; of these different forms of appendicitis Dr. Murphy says, that from the reports of autopsies collected he finds that in 70 per cent. of the cases there was perforation of the appendix, and that of his own cases collected there was 87 per cent. Simple catarrhal appendicitis, if it exists at all, is rarely brought to the attention of the physician, and still less frequently to that of the surgeon; of 194 cases reported he had but one of this variety, but catarrhal inflammation in cases in which the more severe form has previously existed is not uncommon; but the question of greatest importance to the physician and surgeon in these cases is diagnosis. Can we determine when appendicitis is present? In order to answer this question let us consider the symptoms presented in a case of appendicitis. The first symptom in acute appendicitis is abdominal pain of greater or less severity, referred to the epigastrium or umbilical region; in but few cases is the pain referred to the region of the appendix in the early stage of an acute attack. The attack is generally sudden, without any premonitory symptoms; the pain is usually described as colicky or cramping, and is usually followed in a very short time by nausea and vomiting. The term "appendicular colic" has been given to this acute pain, and Dr. Fowler says of this term, that he considers it misleading and liable to give rise to indifference on the part of the med-

ical attendant as to the true condition present and the dangers that threaten the patient, as the term colic has generally been applied to purely functional disturbances of the large and small intestines, and that the acute pains of appendicitis are due, on the contrary, to an inflammatory condition which may rapidly involve the entire organ and place the patient's life in the greatest jeopardy, and if the colic be of appendicular origin, then appendicitis in one of its forms is already in progress. Nausea and vomiting occurring coincidently, or shortly after the abdominal pain, is significant; the vomiting usually ceases when the contents of the stomach has been ejected, and the nausea disappears after a few hours, but may recur on perforation of the appendix or extension of the septic process. The character of the vomit is often of importance as indicating the condition present, as in cases where the general peritoneal cavity is involved the vomited material will be greenish and serous in character. In intestinal paresis the vomited material may be stercoratious as a result of reversed peristalsis. Constipation usually precedes or accompanies the attack, but is not constant, some cases being preceded or accompanied by diarrhea. Tenderness in the right iliac fossa is an early and marked symptom, and taken in connection with sudden abdominal pain, accompanied with nausea and vomiting, it is the symptom of the greatest importance in arriving at a diagnosis; while the tenderness may be more or less diffused over the fossa, yet, on finger-point pressure one point will be found to be decidedly the most sensitive, and this point will usually correspond to the inflamed appendix; this point is usually found to be in the adult from one and a half to two inches inside of the right anterior superior spinous process of the ileum, on a line drawn from the process to the umbilicus, this being known as McBurney's point, and marks the exact point of greatest tenderness in a large majority of cases. This point of greatest tenderness will vary somewhat with the position, length and portion of the appendix involved. Fever to some extent is present soon after the attack begins, and varies considerably, but is no indication of the severity of the attack, for we may have a temperature of 103° Fahr. in a case where the appendix is safely walled off from the general peritoneal cavity, and only a temperature of 100° in another case where the appendix is distended and ready to burst with no protecting adhesions. The pulse is usually accelerated and is of more value than the temperature in determining the condition present, for it will indicate the amount of constitutional disturbance, and this will depend to a certain extent upon the amount of peritoneum involved and the form of sepsis present, but as indicating the gravity of the case and determining when an operation is necessary in these cases, as has been claimed by some observers, it is totally unreliable, for we may have a most serious condition present in the appendix and the pulse give no indication of said condition. Tympanitis is not an early symptom of any importance; it may or may not be present, but when present in any marked degree is an unfavorable symptom, indicating intestinal paresis. Rigidity of the muscles on the right side of the abdomen is a constant and valuable symptom; in general peritonitis there will be rigidity of all the abdominal muscles. Chill during the progress of an attack of appendicitis is a symptom indicating either perforation of the appendix or some extension of the septic process, but is not always present. Œdema of the abdominal wall over the region of the appendix is a symptom of some importance as indicating the presence of pus, but is not generally present early in the disease. Tumor can rarely be detected during the first thirty-six hours of the disease, but is usually present and can be detected on deep pressnre after this time, and sometimes earlier where the appendix is situated close to or in contact with the anterior abdominal wall; the tumor consists of coils of intestines and sometimes omentum with the appendix bound together with inflammatory exudate for the protection of the general peritoneal cavity. To sum up the symptoms then presented in an acute attack of appendicitis we

have only a few that are constant, and these are, first, sudden abdominal pain, general over the abdomen, or referred to the epigastric or umbilical region, soon followed by nausea and vomiting; second, some elevation of temperature and acceleration of pulse; third, tenderness on pressure in right iliac fossa, with greatest point of tenderness on finger-tip pressure at or near McBurney's point; fourth, rigidity of abdominal muscles in region of appendix. These are the symptoms of value and with which we are generally able to make a diagnosis.

As the case advances other symptoms manifest themselves, such as œdema of the abdominal walls over the region of the appendix, tumor, more or less irritability of the bladder may be present, especially in cases where the appendix is long and hanging down into the pelvis. Vaginal examination may be of some service in determining the location of the diseased process, but the information gained by careful history of the case and consideration of the early symptoms, will be of greater value. It is exceedingly difficult in some cases to differentiate between appendicitis, right-sided salpingitis, or pyosalpinx; indeed the appendix may be involvedin these inflammations, and a differential diagnosis will be impossible without exploratory laparotomy. The making of an early diagnosis in appendicitis is of the greatest importance, and it seems to me the diagnosis in these cases is usually easy if the case be carefully watched and the administration of opiates withheld; which, if administered, will often so mask the symptoms as to make the diagnosis uncertain; for this reason, opium, in any form should not be administered until the medical attendant is certain of his diagnosis, and even then it is questionable if the patient is not better off without it. We find, then, that there is a certain group of symptoms present in thesecases from which we can, as a rule, say "this is a case of appendicitis," but so far as I know, there is no set of symptoms that will enable us to say, "this is a case that will recover without operation," or "that is a case that will not recover without operation," and consequently we must regard all these cases as very dangerous to life where operation is delayed, and that the sooner operationis performed the better the chances for recovery, for there is now no question but that nearly all of these cases will recover where operation is done early. These cases generally come under the care of the general practitioner first, and on him rests the responsibility of an early and correct diagnosis. As to the medical treatment in these cases, I believe that a saline cathartic should be administered early in the case where constipation is present. Perfect quiet should be enjoined with absolutely liquid diet, with sufficient doses of phenacetine or antikamnia, or if necessary codea to quiet pain, and that removal of the appendix be advised as soon as diagnosis is certain.

Prognosis—Dr. Fowler, in writing on the prognosis of appendicitis, says: "The prognosis of appendicitis is unfavorable in cases treated non-operatively, in proportion to the severity of the infection; and in cases treated surgically, in proportion to the delay in instituting operative interference." In 176 fatal cases of perforative inflammation of the appendix collected by Dr. Fitz, 60 died during the first five days, 46 during the first four days, and 28 during the first three days, and eight on the second day. These cases show the importance of prompt surgical interference in cases of acute appendicitis. With our present understanding of the pathological condition present in a case of progressive appendicitis, and with a realization of the dangers that threaten the life of our patient, from infection of the peritoneal cavity, retained muco-pus within a constricted appendix, and therupture of this later into an unprotected peritoneal cavity, ulceration and perforation from foreign bodies contained within the appendix, or from gangrenous conditions of the appendix, and the hopelessness of both medical and surgical treatment of these cases when they have reached the stage or condition of diffuse septic peritonitis; and since there are no certain symptoms by which we can distinguish these cases that may be less dangerous and would recover from the present attack without op-

erative interference, and when we consider the uniformly good results obtained by early operation, it seems to me that our duty is clear, and that we should advise operative interference in all cases of acute progressive appendicitis as soon as the diagnosis is clear. In that form of appendicitis known as recurrent, the best time for operation is during the quiescent stage, and there is less danger in postponing operation in this class of cases.

As to the operative treatment in these cases it must vary to suit the individual case, and the stage of the disease. If the operation is done early, before there is much infection of the peritoneal cavity, the appendix should be sought for and removed, and the cavity simply packed with iodiform gauze. Where there is pus in any quantity about the appendix care should be taken not to infect the general peritoneal cavity, by first, packing sterilized gauze about the appendix so as to prevent the entrance of pus at any point where the peritoneal cavity may have been opened, and the pus should be immediately removed by sponging away with sterilized gauze, no water or antiseptic solutions being used in the wound. The appendix should be removed by placing a ligature around it at the base and a second ligature around the mesentery and cutting it away. Drainage tubes are unnecessary where the abscess cavity is small. The strictest asepsis should be practiced in all these cases, both in regard to the cleansing of the field of operation, the sterilization of the instruments, sponges, etc., and the cleansing and disinfecting of the operator's hands. In cases that are operated upon late it may be advisable to simply open the abscess and drain. Where the abscess is opened without opening into the general peritoneal cavity, as is possible in some cases, then there would be no objection to cleansing the abscess cavity by irrigation with sterilized water; but where there is any probability of the general peritoneal cavity being opened into, irrigation should be avoided for fear of carrying the infection into the general peritoneal cavity.

The advisability of removing the appendix in these late operations will be a question for the operator to determine. Where there is a large abscess cavity, with the appendix bound down by adhesions, the danger of infection of the general peritoneal cavity that would be incurred by the breaking up of adhesions in removal of the appendix might justify the operator in leaving the appendix, especially where the condition of the patient is not good, as is often the case, and trust to nature to repair the diseased condition by sloughing away of the appendix, or where a sinus may remain, to a second operation when the condition of the patient has sufficiently improved; but where the condition of the patient will permit, I believe it is better to remove the appendix, if possible, even in these late cases, and with proper precautions there is no great danger from infection of the peritoneal cavity by the necessary efforts to remove it.

In operations on chronic recurring appendicitis, when operated upon during the quiescent stage, the appendix should always be removed, and here the manner of removing the appendix should be somewhat different than in cases operated upon during the early stage; here it is better to remove the appendix by making a cuff of the peritoneal coat, stripping it down as you would the integument in a circular amputation; then place ligatures about the appendix and remove it by cutting the muscular and mucous coats; disinfect the cavity of the cut extremity, turn the cuff back over the stump and suture, thus burying the cut end of the muscular and mucous coats beneath the peritoneal cuff.

In these cases the abdominal wound should be closed and small drainage tubes with strip of gauze to bottom of the wound.

As to the treatment of cases where there is general infection of the peritoneal cavity, or a greater part of it, diffuse septic peritonitis, these cases have generally been regarded as hopeless, and the percentage of recoveries has been small. Indeed the mortality in these cases has been so large that many surgeons have advised non-interference in many of these cases. In the *Medical Record* of March 30, 1895, is an article by Dr. McBurney on the treatment of this

class of cases. He reports twenty-four cases on which he has operated during the past two years, of which fourteen recovered. All these cases were treated by incision, irrigation with sterilized salt solution, drainage by strips of gauze and glass drainage tube extending of the most dependent part, but adds that he has had quite a number that he considered to be in too hopeless a condition to justify operative interference, which were allowed to die without operation, but the results he has obtained by this plan of treatment are certainly much better than that obtained by any other method that I know of.

DISCUSSION.

Dr. Peers: A physician in the Cook County Hospital who has investigated over a hundred cases finds that there is a surprising number of cases of inflammation of the cavity which have been overlooked and have recovered without loss of life, and he finds there are three locations in the abdomen particularly liable to this inflammation, viz.: The appendix, the gall bladder and the sigmoid flexure. He finds that there is a large number of inflammations of these organs that recover. With this fact before us, it seems to me that we should hesitate about saying that every case of appendicitis should be operated for. We ought to be able to find some way of distinguishing these cases so that every case should not be operated upon; but in the general practice we have not things completely under our control. There are some cases that call for operation, and if we could say with certainty, "Your child is going to die," or "this person is going to die unless an operation is performed," our statements would carry great weight; but where we see that patients recover, as they often do, it is humiliating to the physician; but if there were some way of making more accurate diagnosis, so that the physician could say with certainty that a patient would die unless operated upon, it would be more satisfactory to the profession and to all concerned.

Dr. Gray: I do not know that I have anything to say in conclusion. In regard to the opposition to operation, the reluctance to submit to operation, I believe the patients should be told by the medical attendant that operation is the proper thing, as offering to them the largest chance of recovery. They will not necessarily die; they may recover from several attacks, but as some one has very appropriately said, they never die from but one attack. Of these fifteen cases which I did not have time to report, there were two deaths, resulting from general or diffused septic peritonitis on the fourth and fifth day from the commencement of the attack. The other cases recovered.

E. B. TREAT, publisher, New York, has in press for early publication the 1896 International Medical Annual, being the fourteenth yearly issue of this eminently useful work. Since the first issue of this one volume, reference work each year has witnessed marked improvements; and the prospectus of the forthcoming volume gives promise that it will surpass any of its predecessors. It will be the conjoint authorship of forty distinguished specialists, selected from the most eminent physicians and surgeons of America, England and the Continent. It will contain reports of the progress of medical science at home and abroad, together with a large number of original articles and reviews on subjects with which the several authors are especially associated. In short, the design of the book is, while not neglecting the specialist, to bring the general practitioner into direct communication with those who are advancing the science of medicine, so he may be furnished with all that is worthy of preservation, as reliable aids in his daily work. Illustrations in black and colors will be consistently used wherever helpful in elucidating the text. Altogether it makes a most useful, if not absolutely indispensable, investment for the medical practitioner. The price will remain the same as previous issues, $2.75.

WE have a Yale Chair in first class condi tion, for sale.

Kansas Medical Journal.

PUBLISHED WEEKLY

BY THE MEDICAL PUBLISHING COMPANY.

SUBSCRIPTION PRICE, INCLUDING POSTAGE:

Per annum, in advance..... $1 00
Single copies..... 15 cents

Subscription may begin at any time. The safest mode of remittance is by bank check or postal money order drawn to the order of the undersigned. When neither is accessible, remittances may be made at the risk of the publishers, by forwarding in Registered Letter. Address

KANSAS MEDICAL JOURNAL,
631 Kansas Avenue.

W. E. McVEY, B.S., M.D., EDITOR.

COLLABORATORS:

J. E. MINNEY, A.M., M.D., Topeka, Kas.
S. G. STEWART, M.D., Topeka, Kas.
J. C. McCLINTOCK, A.M., M.D., Topeka, Kas.
M. B. WARD, A.M., M.D., Topeka, Kas.
W. S. LINDSAY, M.D., Topeka, Kas.
JOS. B. CONNELL, B.S., LL.B., M.D., Kansas City, Mo.

Topeka, Kansas, Saturday, Dec. 21, 1895.

The Old and the New

Old age lives in the past, youth in the future.

The deterioration in the mental agility of many once noted men of all professions is a sad but most notable fact. Men who have stood at the head of the professional world, men who have once led the political forces through great trials of party strength, and have mounted to the highest pinnacle of political fame, in their old age fall back upon past achievements to awaken sympathy or appreciation. They cannot appreciate the advances made in science or the changes in methods which have been adopted by a younger, and possibly more progressive, generation. Science takes long strides which these men, from lack of enthusiasm and sluggish minds, do not appreciate; achievements which, in their younger days, would have been heralded with great applause, are received with doubt and suspicion. They have passed the age of improvement, and to them experience is worth more than experiment and investigation.

There are many exceptions to the rule and many variations of the age at which decay begins, but the fact is nevertheless most prominently manifested in some men who, in their younger days, have held the highest honors in the gift of their commonwealth. An ex-governor of the great State of Kansas, in his egotism and his ignorance, publicly proclaims to the world that there has been no progress in the science of medicine or surgery else the surgeons would have been able to restore the lamented Garfield to a loving people. Did he cease to live when Garfield died, or did he, at that time, reach the period of mental decline? He lived, physically, for we have his recent utterances, but from those very utterances we must conclude that for the past fifteen years his mental pabulum has been an exclusive memory.

He cannot comprehend the immense strides that have been made in surgery during the past fifteen years; he does not recognize that some of the greatest discoveries, that some of the greatest boons to human kind, have reached his world during the past fifteen years. For during this time progress has been incomprehensible, impossible, to him. He has lived in the past.

The Topeka Academy of Medicine and Surgery.

The Topeka Academy of Medicine and Surgery met in A. O. U. W. Hall, December 9, 1895, with Dr. Ward in the chair.

Minutes read and approved.

The following members were present: Drs. Magee, Longshore, Wall, Wehe, Ward, Barnes, Lindsay, J. C. McClintock, Munn and Grubbs; visitors, Dr. McLaughlin and medical students.

Dr. Longshore read a paper upon "Tonsilitis," followed by discussion.

Dr. Munn: There is a close relationship between inflammations leading to abscess, follicular tonsilitis and diphtheria. In looking up this subject some years ago, remember finding records of different families, certain members of which had true diphtheria as shown by the Klebs-Loeffler bacillus, while others simple tonsilitis as evinced by an absence of bacilli of this type. The removal of hypertrophied tonsils, a simple operation which gives great relief. Have no great fear of hemorrhage after operation; saw one case in which it was severe, but stopped when the patient fainted; easy to plug the throat. There are reports of hemorrhage stopped by pressure of thumb on bleeding surface; may ligate vessels.

Dr. Grubbs: Differential diagnosis is essential and easily made early. There are three forms—parenchymatous, follicular and peritonsilar abscess. In the simple parenchymatous type, the tonsils only are involved; when follicular the pulse pours from the spongy portion of the gland, and in peritonsilar abscess the inflammation is about the tonsil. It is useless to attempt to drain quinsy by piercing the tonsil; must cut above and be careful not to reach the internal carotid or ascending pharyngeal artery; make a slight cut and then by means of a probe work into the abscess cavity. Believe that tonsilitis is often due to rheumatism since the salicylates will often cut short; removal of tonsils or a portion of them usually prevents return. When rheumatic tendency, exposure to cold may precipitate the inflammation. I usually prepprescribe salicylate, calomel to relieve bowels, and some antiseptic wash. Life may be destroyed by suffocation, as Dr. Longshore has said. The internal carotid, or ascending pharyngeal artery, may become eroded, causing death by hemorrhage.

Dr. Lindsay: Recently have seen a case presenting the symptoms and pathological appearance of follicular tonsilitis in the beginning, which within a week developed the spreading gray membrane of diphtheria; used antitoxin, the line of demarkation was established and the membrane disappeared. Made three examinations of the membrane in the active inflammatory stage; also two cultures, but found no Klebs-Loeffler bacillus; then injected the culture into a rabbit, which became very sick but did not die, and there was no deposit of membrane upon wound.; cannot always diagnose diphtheria. The condition we call lithemia, the basis of tonsilar affection, rather than rheumatism; the retention of effete matter in the system, the condition which underlies all these troubles. Whatever germs find lodgement mark the character of the disease. Removal of tonsils questionable; may remove part if obstructive; but if the theory that the tonsil is the home of the white blood corpuscle, the phagocyte, stationed there to resist the inroad of the bacilli, better not remove the tonsil. Take away a very small part of tonsil, if at all.

Dr. McLaughlin: Prescribed mercury in the earlier days of my practice, chalk mixture and calomel, with good success; do not often use them now. When see case soon after initial chill, give an active cathartic, sulphate of magnesia, saturated solution, which I give in any inflammation. Am confident that I have often broken up attacks in my own case. Agree with Dr. Grubbs that the causes that will produce rheumatism will also give rise to throat trouble; also believe that the digestive tract needs a thorough cleansing. The blood vessels are enlarged and the veins full; use iodine during interval for prevention. Two years ago had a peculiar case; called it diphtheria. Patient, a little girl of two years: The membrane appeared after a few days (I made no microscopical test), and spread from tonsil to the uvula, which sloughed off. The recovery was good.

Dr. Magee: With regard to the function of the tonsil, there is a current opinion among the laity that removal of the tonsil impairs or hinders development of the sexual organs. During the last year have observed a number of cases with this in view and find a contrary result obtained. If tonsils are enlarged, difficult respiration and deglution give rise to sluggish movements

and dullness, while after removal the patient becomes bright and alert. Have in mind a boy, who was thought to have some lung trouble, was weakly and sickly, but since tonsils were removed is strong and well and stands erect. The tonsil belongs to the glandular organs, and excessive growth in one direction means a diminution in another. If this is so, when tonsils enlarged, suppurating regularly, pus being swallowed, an interference, with digestion manifest, have good cause for their removal.

Dr. Wehe: The tonsil is a lymphoid follicle, plenty of white blood corpuscles, mucous exudate may be mistaken for diphtheritic exudate.

Dr. Ward: Did any one ever notice that enlarged tonsils may affect the nervous system and give rise to chorea? I had one such case and the chorea closed after removal of tonsils.

Paper received for publication.

Paper by Mr. E. A. Wagener, "The Expert Witness." Discussion:

Dr. Wall: Could a physician refuse to give an opinion by saying he did not know?

Mr. Wagener: If he did not know.

Dr. Grubbs: Can the court compel a physician to procure knowledge which is available, but not in his possession, without extra remuneration.

Mr. Wagoner: No; but can compel him to state opinions in possession for the ordinary fees of the regular witness. This holds good among all classes of men, no matter how important their position, who are compelled to serve the public interest when called upon. The lawyer is often called by the State to defend the poor, and must do it.

Dr. Lindsay: A question of equity, compelling a physician to give information for $1.50 per day, may be called where ample wealth, or by State, not parallel with the pauper case of the lawyer. Are not physicians taking care of the poor every day in the year? Another point: The doctor goes before the jury to tell what he knows, not for effect on the jury, and therefore ought to be called by the court and maintained by the court. The New York Board of Expert Witnesses is called and maintained by the court. Members should be appointed because of fitness for it. This law seems very reasonable.

Dr. Wall: The position of a physician as a medical expert is often made one of ridicule. Expert witnesses differ where they should not. The court, judge and jurors think each expert witness is prejudiced by the defense or prosecution, by whichever side called, and pay no attention to the testimony. Think the State Board a good thing. Some lawyers ask questions to which there is no possible answer.

Dr. Munn: Think that members of the New York Boards have been accused of receiving money for testimony. Believe we owe something to the State.

Dr. Lindsay: We are giving our time every day.

Paper received for publication, with vote of thanks to Mr. Wagener.

Report of a surgical case, with presentation of pathological specimen by Dr. Ward: This fibroid tumor was removed three weeks ago from a patient who, although suffering from the most severe symptoms of this condition, was able to come to Topeka four days before, a distance of eighty miles, and return.

She is 34 years of age, and states that ten years ago her family physician found small fibroids around the cervix uteri.

No attention was given to this condition, although for some years now the patient has suffered from pelvic pain and discomfort.

Pathological conditions in pelvis, as elsewhere, should be removed if can assure patient of restored health without undergoing too great risks.

The temperature ranged from 99½° to 100°; pulse 120, very weak.

The abdomen was very much distended, the ensiform cartilage projecting markedly. The enlargement was very rapid recently. She has however, been able, as women will, to work during the last two months. I thought there was fluid in a cyst. Found in the abdomen a large amount of ascitic fluid—eight gallons.

The tumor and peritoneum were gan-

grenous anteriorly over a space of about six inches in diameter. There was great hemorrhage, blood flowing from all parts of the spongy tissue. Could not arrest hemorrhage by ligature of broad ligament. Had nine or ten tumors. Patient pale and ghastly.

Applied the clamp as quickly as possible, could not stop to look for bladder or ureters.

After clamp adjusted found bladder all right.

Drained the abdomen with gauze, which stopped the hemorrhage from the gangrenous omental surfaces. The gauze was removed the next morning and replaced with a smaller amount, and later in the day chloroform was given, and the peritoneum attached to the stump with catgut stitches, beneath the wire of the serre-noeud, the upper end of the wound having been properly closed, and silk stitches employed to secure more firm attachment to the stump.

After operation temperature was never above 100°; pulse 102. Patient is making a good recovery.

Standing committees were appointed as follows:

Board of Censors—Drs. Grubbs, Wall and Longshore.

Committee on Laws—Drs. Peers, Lewis, and R. E. McVey.

Committee on Finance and Hall—Drs. Munn, Wehe and Lindsay.

The program for the January meeting is as follows:

"Scientific Optician Glass Fitting," Dr. G. A. Wall.

"A demonstration of the Biological Character of the Typhoid Bacillus and Allied Species," Dr. J. L. Gilbert.

Report of case, Dr. Sheldon.

Society adjourned to meet the second Monday in January.

IDA C. BARNES, M.D., *Secretary*.

The Use of Short-Hand in Medicie.

Medical Record.

What seems at first glance to be a curious little side-path in the history of medicine associations, is the establishment in England a year ago of the Society of Medical Phonographers. What in the world, one is tempted to exclaim, does a physician want with short-hand! Hasn't he enough to do without burdening his mind with a new art, and one that can have no relation whatever to the science or art of medicine? But the arguments of the founder and supporters of the new society, which now numbers nearly two hundred in membership, cannot be thus dismissed off-hand. The mere fact of the existence of such an association is an evidence that those who use short-hand find it so helpful to them that they are willing to be at some pains to extend its benefits to others. In his inaugural address before the Society, the President, Dr. Growers, presented the claims which the science of phonography has to the attention of medical men, old practitioners as well as first-year students; and possibly it may help along the work, which we cannot but regard as a good one, if we review briefly the speaker's arguments for the benefit of the Society of Medical Phonographers.

The need of writing, for a written record is absolute in medicine as in every science that rests on observation, for memory cannot be trusted, and immediate record can alone make observation effective. But with the aid of short-hand twice the amount of record that is possible with long hand can be made, and yet there will remain a longer time in which to observe. Furthermore, many fleeting events which might escape record in long hand can be noted and preserved in memory forever by the winged characters of phonography. As was well said the Bishop of Hereford, in a letter read at this same meeting: " Short-hand puts a new instrument into the hand of the observer, an instrument which must be specially valuable when you have to deal with subtle and quickly changing phenomena."

Thus the observer, having the means at hand for recording the evanescent phenomena, gradually acquires the habit of looking for them and observing them. Short-hand is like a lens that brings to the consciousness of the observer many minute but most important points, that would possibly other-

wise escape him. The often-quoted words of Bacon, that "writing maketh an exact man," acquire a fuller significance when the writing is short-hand writing.

But the use of short-hand does not stop at the record of observation. "It is equally available," says Dr. Growers, "with the same saving of time and labor, in the processes of comparison of observations, of epitomizing the facts observed by others, and in all the preliminary work of composition. Indeed, I have frequently written the final copy in short-hand; typewriters transcribe it with accuracy."

It may be thought that these remarks have little application to the work of the practitioner, but, on the contrary, the value of short-hand in medicine finds, perhaps, its greatest expression in the aid it can give to the practitioner. "Without the use of writing, the facts that pass before him will leave only a transient furrow on the sands of unaided memory, vanishing for the most part when new facts disturb the surface, or at most leaving but a slight modification in mental tendency. The vast effect of unrecorded—and therefore unconsidered—'experience' is too often a warping of judgment by the influence of some striking but exceptional fact, conspicuous in vague outline in the memory, while the conditions essential to its interpretation are forgotton. Only habitual, immediate record can preserve from these dangers the 'science' on which depends the work of the practitioner and the welfare of his patients. For this result the record of that which is observed must of course be utilized, and so arranged that its value shall not be lost. Yet the mere process of record gives, as we have seen, precision to observation, and secures retention not otherwise to be obtained."

Of course, there are objections that may be urged against the use of short-hand, but the drawbacks are slight in comparison to the advantages of the accomplishment. The contention that note-taking weakens the memory is an objection that applies equally to the taking of long-hand notes. Few men, if any, have a memory that never plays them false ; and, moreover, it is the experience of most people that writing down a fact helps to fix it in the memory. Another objection, and really the only one of any real force, is that neither the student nor the practitioner can spare the time necessary for the acquirement of a ready knowledge of short-hand. But anyone can learn to write with sufficient rapidity, say three times that of long-hand, by practising two hours a day for two months, and the one huutred and twenty hours thus spent will be saved and repaid several times over in the next two years. Short-hand is illegible is another objection urged against it. But the experience of those who use it is that it is not illegible when written carefully and at a moderate speed. The notes of a stenographer making a verbatim report of a political meeting may perhaps be illegible to all but himself ; but short-hand can be written with three times the speed of long-hand and be fully as legible, not alone to the writer but to all phonographers, as long-hand.

Dr. Growers deserves the thanks of all who are interested in the advance of medical science and of individual progress for his disinterested labors in promoting the diffusion of a knowledge of short-hand among members of the profession, and we hope that he will find his reward in the prosperity of the Society which he has founded, and which has honored itself in choosing him as its first presiding officer.

Bacteriology In Church.

Pacific Medical Journal.

Since science has turned her search lights upon the teeming tiny micro-organisms, they have been found almost everywhere. If not the root of all evil, they are the root of all diseases. That they would finally invade the church militant was to be expected, but that they should find their way into theology even before they were recognized as disease breeders by the old fogies of our own profession is rather remarkable. It goes to show that the scientific spirit is abroad, and that in every profession and walk in life there are a few men at least who are

capable of keeping abreast of the times in which they live. The Rev. V. M. Law has iuvented an *individual* communion cup. Mr. Law is an Episcopal clergyman and asked his fellow clergyman to examine the cup, to hear his argument in favor of its adoption and his objection to the present method of conducting the communion service. The clergy would have none of it. Mr. Law's cup met with the usual fate of innovations. One clergyman thoughe it "a blow struck at Christian reverence," another thought the Lord could take care of his own children. The Lord has never to our knowledge protected the poor pilgrims of Persia and India against cholera when in their ignorance and fanaticism they drink cholera-infected water. In fact, neither ignorance, fanaticism nor superstition lessens the remorselessness of consequences. It is quite evident that our brethren of the church have not yet realized that the misrobe is "the pestilence that walketh in darkness and the destruction that wasteth at noon." Mr. Law must not be discouraged, he is only a little ahead of his time; his is not the first voice that has cried in the wilderness. It will not be many years until few things will be more repugnant to an intelligent person than to expect him to put his lips to the same cup or glass from which two or three hundred have already sipped. The means of protecting oneself against contagious disease is not a subject too sacred for secular discussion, nor will it be considered a blow at Christian reverence to avoid scarlet fever, or diphtheria, or syphilis, nor will the wine, in the cup prevent an abrasion of the lower lip from leaving active bacilli on the cup rim. There may be and often is death on the cup as well as in the cup.

A New Treatment for Simple or Complicated Fractures of the Fingers and Toes.

New York Medical Journal.

The *Presse Medicale* for Nov. 2 publishes a description of a new apparatus, which was invented by M. Schmidt, for the purpose of practicing extension, using the nail of the fractured finger as a means of support.

The apparatus itself is composed of a small board made more or less in the form of the palm of the hand or of the sole of the foot. Near the edge of the board, which should rest against the root of the digits, is an extension on which the fractured finger or toe is placed. On the end of the extension is a hook. In applying this apparatus there must be ready for use a gimlet, strong silk or ordinary thread, a needle and a rubber tube. The procedure is as follows: At some distance from the free edge of the nail two holes are bored with the gimlet at equal distances on each side of the median line of the thumb. Then with a needle the two ends of thread are passed through the holes (the needle must pass from the palmar surface to the dorsal surface of the nail), and after this is done the board, covered with a layer of cotton, is slipped under the hand and placed in such a manner that the healthy fingers may clasp the free edge. and the fractured finger is placed on the extension. The opposite edge of the board is then attached to the hand by means of small bands of adhesive plaster passing around the wrist. A band of tarlatan wrapped around the board and the hand, but leaving the fingers free, holds the apparatus in place. On the hook at the end of the board the rubber tube is placed, the two ends of which are strongly tied, and, in drawing on the loop in the direction of the finger, the two ends of the thread, which pass through the holes in the nail, are attached to the rubber tube. At this moment the fracture is reduced and the fragments are held in place owing to the extension and to the counter-extension accomplished by the thread and the rubber tube. During the first three days the traction should not be strong, in order not to strain the nail too much; but from the fourth day traction should be increased by tightening the thread. The apparatus is left in place from two to three weeks.

According to M. Schmidt, his apparatus presents considerable advantages, such as free circulation in the fingers; the frag-

ments do not rub against each other, and the seat of the fracture being exposed, the physician can easily watch the position of the fragments. Massage may easily be applied, also the necessary dressings in case of complicated fractures, etc. Furthermore in cases of articular fracture the extension prevents ankylosis or articular rigidity.

In twenty-five cases in which this treatment has been employed, says the writer, onychia has never been observed. Sometimes a softening of the root of the nail supervenes, which disappeares, however, as soon as the apparatus is removed. In two cases only this softening lasted until the nail fell out, pushed by the new one which had formed underneath it.

Northwest Kansas Medical Association.

Following is the program of the meeting of the Northwest Kansas Medical Association to be held at Wakeeney, Kansas, Tuesday, January 14, 1896:

1. Renal Calculi—Dr. J. W. Tulles
2. Iritis—Dr. W. S. Harvey.
3. New Remedies—Dr. A. B. Jones.
4. Ovariotomy—Dr. S. E. Sheldon.
5. Railway and Accidental Surgery—Dr. H. Z. Hissem.
6. Meningitis—Dr. J. W. Robb.
7. Dislocations—Dr. J. W. Winslow.
8. Fractures—Dr. J. N. Page.
9. Volunteer report of cases.

A Subscription Offer.

We have made arrangements by which we can furnish our subscribers with a pocket tablet case, filled with the following assortment, at a very low price. We will send you this case, which is worth $2.50, and the KANSAS MEDICAL JOURNAL for one year for $3:

CASE NO. 1—ASSORTMENT A.

A folding pocket case made of blue-black Russia leather, closing with a substantial clasp; length, 7½ inches; width, 3½ inches.

Two rows of 12 vials, each having a capacity of about 45 Tablet Triturates. The vials are closed with a metal screw cap.

REGULAR SELECTION:

No.	
68	Dover's Powder, 1 gr.
72	Ergotin (Bonjean), 1-10 gr.
98	Mercury with chalk, 1-10 gr.
117	Morphine sulphate, 1-16 gr.
126	Nux vomica, Powdered, 1-10 gr.
132	Pepsin Aseptic, 1 gr.
142	Podophyllin, 1-16 gr.
151	Quinine Sulphate, 1 gr.
156	Santonin and Calomel.
186	Sodium salicylate, 1 gr.
217	Aloin Compound "R.A."
639	Acetanilid, 1 gr.
257	Aconite, tincture, 1 min.
267	Ammonium chloride and Hyoscyamus Compound.
312	Calomel and Soda.
314	Camphor monobromated, 1 gr.
321	Cathartic Comp., Improved, 1-5 gr.
362	Digitalis, tincture, 1 min.
454	Neuralgic (Dr. J. H. Kenyon).
618	Nitroglycerin Compound.
625	Bismuth Compound.
628	Diarrhœa.
630	Fever (Dr. T. G. Davis).
645	Tonsilitis.

Eight Hundred Pages for $1.

In 1896 the *Tri-State Medical Journal*, an illustrated monthly medical magazine, will give its subscribers 800 pages of select medical literature for one dollar. Clubbed with the KANSAS MEDICAL JOURNAL for $1.80. Address *Tri-State Medical Journal*, 3509 Franklin avenue, St. Louis, Mo.

A Pharmaceutical Triumph.

There is probably no laxative or cathartic in the materia medica which is more widely known and more generally used, especially as a home remedy, than castor oil.

Its only objection has been its taste. Now, however, even this has been removed, and we have "a pleasant castor oil."

Laxol is pure castor oil sweetened with benzoic sulphinide and flavored with oil of peppermint.

By referring to our advertising pages the readers of this journal will learn how they can procure samples and literature without expense.

Laxol is used throughout many of the best hospitals in the East, where it has been known for some time.

Case V.

The Mercer Chemical Co., Omaha, Neb.

I am very favorably impressed with all your formulæ, but especially with Pill Vita. I ordered them for a patient (a married lady) who seemed devoid of any sexual feeling whatever, having no desire for coitus and only submitting from a sense of duty. It gives me pleasure to inform you that two bottles of your Pill Vita have materially changed this condition, and the patient is rapidly gaining in sexual power. Previous to this treatment she had used almost every other aphrodisiac in the market with no effect. Please send one-half dozen bottles and oblige.

S. J. BRIETZ, M. D.,
Hamilton, Ark.

Peroxide of Hydrogen.

By J. F. Parker, Ph. G., M. D., of St. Louis, Mo. Published by the Annals of Ophthamology and Otology, of St, Louis, Mo., April, 1895.

(Abstract from The Times and Register, June 8, 1895.)

I have used peroxide of hydrogen quite extensively for cleansing discharging ears, the nasal and accessory cavities, and have tried all the brands of the preparation in the market, and once thought one manufacturer's make as good as that of another, and bought the cheapest as a matter of economy, but recent experience has taught me that the difference in quality is greater than the difference in price. After an unpleasant experience with a solution of peroxide of hydrogen which severely injured the mucous membrane, I bought and examined, chemically, a bottle of each preparation of H_2O_2 in the market, and was surprised to find so much difference. Some are useless, and others worse than useless because they contain too little available oxygen and too much free acids (phosphoric, sulphuric, hydrochloric). I now order Marchand's (medicinal) exclusively because I find it contains the desired quantity of available oxygen, and not enough free acid to be objectionable, and its keeping properties are all that could be desired.

By inquiry I learn that Marchand's is the preparation that is used by almost all surgeons, and it is considered by them the standard.

—[My personal experience with peroxide of hydrogen confirms entirely the statement of Dr. J. P. Parker. I have used exclusively Marchand's brand until lately, when I experimented with hydrozone. Then I gave up entirely the use of peroxide of hydrogen and use hydrozone on account of its strength, which cannot be compared with any other brand, even Marchand's. I must say that the results which I obtained with hydrozone are most gratifying.—ED.]

Case I.

The Mercer Chemical Co., Omaha, Neb.:

GOTHENBURG, NEB., October 25, 1894.—*Dear Sirs:* Mr. W——, aged 30, married over two years. Since having an attack of paralysis of the left side has suffered complete impotence—I say complete advisedly, as he has not experienced in all that time even a partial erection. But I must confess my great surprise and satisfaction after 24 days' treatment with your Pill Vita (Blue) to have the patient report himself entirely cured, and the vercict—guilty of using Mercer's Pill Vita (Blue)—has created happiness and reunited a happy couple. Respectfully,

DR. W. P. SMITH,
Ass't Surg U. P. Ry.

WANTED—A young physician who is a graduate of pharmacy or can register and can loan employer seven hundred and fifty dollars ($750) for six months. Note secured by drug stock. Steady job with good salary. Address "Pedra," care KANSAS MEDICAL JOURNAL.

RENEW your subscription.